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ABSTRACT

Increasing numbers of adolescents are experiencing deep depression and instances of adolescent suicide are increasing at a rate 10 times faster than for adults. Predisposition to suicide can be classified into three categories: biophysical, situational, and syndromatic. Adolescents suffering biophysical disorders are most easily identified by their deviant and dysfunctional behavior. The category most associated with social conditions is situational. The syndromatic category is associated with real or perceived change in status and may be exacerbated by the school. While a number of verbalizing, behavioral, and performance behaviors exist that typically signal an at-risk child, there is no identifiable sequence and the signs can appear together, over varying time periods, or without warning. The most easily recognized symptom is preoccupation with death and a declaration of hopelessness. Behavioral signs are more difficult to recognize as adolescents quite normally experience mood swings. When it is suspected that a child is suicidal, intent and lethality must be assessed. The individual should be confronted in a direct, non-threatening manner. Time is critical and confidentiality cannot be considered. Schools and teachers need to help youth gain personal confidence and look to the future with an optimistic attitude. (NB)

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Curbing Adolescent Suicide: Conditions, Symptomatic Behaviors, and Intervention Tactics

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The adolescent years, frequently remembered by adults as carefree and fun filled, are in reality often fraught with insecurity and self deprecation. Physically, socially, and psychologically young people are struggling to discover personal identity as they transcend the protected stage of childhood and anticipate adult roles. The demographics of contemporary society are exerting increasing pressures and providing fewer areas of stability and predictability. As a result increasing numbers of adolescents are experiencing deep depression and despondency. Growing numbers are taking their own lives.

The instances of adolescent suicide are increasing at an alarming rate, ten times faster than for adults. It is the second leading cause of death for those between the ages of 15 and 19; there has been a 200% increase in the last two decades. Those taking their lives are becoming increasingly younger. Last year more than 100 under age 14 committed suicide. In 1957, 4 of 100,000 died by their own hands; by 1985 the rate had risen to one in 13,000 and continues to accelerate (U.S. Center for Health Statistics). Ray and Johnson (1983) contend that the numbers are conservative since medical and law enforcement personnel are often reluctant to classify a premature death as suicide in deference to the grieving family.

These data become more sobering when the number of attempts are considered. For each death it is estimated there have been 30 to 40

attempts. Approximately 12% who made an aborted effort this year will be successful by 1989. Four of five who die have failed previously. It is estimated that 12% of those who make an attempt this year will be successful by 1990. (Bruno Affiliates, 1985).

Girls try to take their lives 3 times more often than boys but employ less lethal methods which reduces the risk. Boys are successful 4 times more often (Bruno Affiliates, 1985).

The complexity of contemporary society and demographic realities are exerting different pressures on youth than existed in the past (Garfinkel, Froese, and Hood 1982). What is happening to these young people who are so protected? Never before, in history, has society invested so much effort to provide a "good life" for youth. Young people, today, have few opportunities to enter the world of work or, if they do, their earnings do not typically contribute to family resources. Such demands on previous generations may actually have served to provide purpose and a means of venting frustrations through productive effort. While the schools are not entirely to blame, they represent a common experience for all youth in this country and, therefore, can and must assume a major responsibility for intervention.

Contributing Conditions

Predisposition to suicide can be classified into three categories: biophysical, situational, and syndromatic (Hyde and

Forsyth, 1987). Each category shares the risk factor but treatment varies.

Students who suffer biophysical disorders are most easily identified. Their behavior deviates significantly from the norm reaching a point at which they can no longer function with their peer group. They exhibit noticeable mood swings, elation followed by deep depression. Behavior becomes totally unpredictable and inconsistent with circumstances. In some cases the condition is a genetic one, triggered by the hormonal imbalance associated with the onset of puberty. Other instances are drug related, when there is habitual use extending over a period of time.

Parents often deny the problem and need the support of school personnel to seek professional help. Hospitalization is required and lithium has proven highly effective for those between the ages of 15 and 20 (Hyde and Forsyth, 1978).

The category most associated with social conditions is situational. During the transitional period of adolescence youth are quite normally struggling to discover personal identity. They have difficulty putting events into perspective and lack the experience and inner resources to cope with change (Kazdin, 1982).

Peer relationships are tenuous and there is a desperate need for stability and predictability in their contacts with significant adults. The high mobility of contemporary society and the fragmentation of family bonds is threatening. Young people feel

manipulated and disregarded when circumstances necessitate a move. An even greater threat occurs with a radical change in family structure through death or divorce (Rogers, 1985).

The reconstituted family presents a challenge at a time when the child is preoccupied with his/her own physical changes and social roles. When parents date there is serious emotional reaction. If the parent remains single there is a tendency to form a different attachment to their child. If remarriage does occur, there may be new siblings with which to share parental attention and family resources (Rogers, 1985).

The degree to which family relationships contribute to suicidal behaviors can be concluded from the data. Most adolescents who attempt suicide, 71%, are from broken homes. Nine of ten attempts occur in the home, 70% while a parent is present (Bruno Affiliates, 1985). There may be a need to draw attention to personal concerns or a desire to punish parents for decisions not easily understood. There may be an expectation that they will be saved, while punishing parents or making a social statement.

The third category, syndromatic, may be exacerbated by the school. This is associated with real or perceived change in status. It may be as transitory as acne, growth related appearance or as permanent as disfigurement from an accident. New responsibility associated with the entry into adult society can be exceedingly

stressful. Seventeen year old girls who have given birth are 7 times more likely to take their lives.

Competition is a hallmark of this culture and is perpetuated in the educational system. The "star system," common in junior high schools, contributes to great pressure to excel.

An illness or accident which prevents an athlete from participation can lead to intense depression. Outstanding performance in creative and academic pursuits should be rewarded but active, enthusiastic participation is seldom heralded. When children expect they have not met expectations they can feel valueless.

Symptomatic Behaviors

There are a number of behaviors that typically signal an at-risk child. All may be exhibited or there may be no warning at all. There is no identifiable sequence and the signs can appear together or over varying time intervals. These behaviors can be grouped into three categories: verbalizing, behavioral, and performance. It is a myth that those who talk of dying are seeking sympathy. Data reveal that 60 percent who commit suicide have at one time confided intent (Hyde and Forsyth, 1978). The most easily recognized symptom is preoccupation with death and a declaration of hopelessness.

Behavioral signs are more difficult to recognize as adolescents quite normally experience mood swings. However, obvious attitude changes should signal a need for counseling. When a gregarious

child suddenly becomes moody and withdraws from social situations, or a reticent one becomes flighty and demonstrative, teachers should pay heed. Some normally prudent students will suddenly take unwarranted risks (Weinberg and Emslie, 1987).

The third category is associated with sudden changes in performance. A child may become compulsively organized, cleaning out a locker, their room, and attending to tasks they have been procrastinating. They may give prized possessions to selected friends. It isn't uncommon for them to pay careful attention to personal grooming. They may even have a physical or go to the dentist for a check-up. About 75% of those who take their lives have been to medical personnel within 3 months of the act (Bruno Affiliates, 1985). It is as if they are fantasizing the aftermath of their death and want to control conditions. In many cases the child appears to be more peaceful in the last days when the decision has been made and plans finalized (Konopka, 1982).

Intervention

When it is suspected that a child is suicidal, intent and lethality must be assessed. The individual should be confronted in a direct, non-threatening manner. Express concern for their feelings and ask about intentions.

Arguing can strengthen resolve but probing questions will force the child to consider motives. Adolescents feel immortal. They

most often don't expect to be dead but glamorize the act of dying. Explaining consequences is ineffective but forcing an individual to verbalize personal feelings and reflect on the effect on others helps them to clarify their own motives (Schneidman, Farberow, and Litman, 1976).

If the plan has been carefully formulated, lethality must be evaluated. If they have access to the means for ending their lives then there must be prompt action to avoid an impulsive act (Kosky, 1983).

Time is critical. When a child reveals intent, extract a promise to delay action until a specific time. This enables them to reconsider but of greater importance, it allows the teacher to contact professional help.

Confidentiality can not be considered. Even when the child feels a teacher has violated trust, contact must be maintained. If the child is referred and dropped, he/she will feel abandoned. Though they typically reject friendship, it is imperative that the confidant show acceptance and persevere. When the healing process begins, a victim will once again be at risk and the bond will aid adjustment. The greatest danger of a repeated attempt is during the first three months of recovery (Konopka, 1982).

Adolescents are highly suggestible (Rogers, 1985). There is a danger of serial or cluster suicides when a classmate has taken his or her life. Mourning should be private. Tributes in school, as-

semblies, and group attendance at funerals only serve to dramatize death. Mass expressions of sympathy and remorse exacerbate emotional reactions and create conditions for some students to emulate their honored dead classmates.

Following such a tragedy, the desk should be left in place until after the funeral as acknowledgement of the loss. Friends may be excused to attend services but the victim should not be treated as a hero. School personnel need to call on the family and teachers should have an opportunity to attend the funeral. Parents must know others share the loss and students need to recognize that school personnel genuinely care.

Summary

Youth today are unsure about their roles and society provides few opportunities for them to make substantial contributions. They feel manipulated and lack the inner resources to effectively deal with change. Many are suffering from feelings of helplessness and hopelessness leading to genuine despair.

For many, school represents the greatest stability in their lives. School personnel need to be knowledgeable about social/emotional development and sensitive to their personal pressures. They need to be alert to signs of despondency and be available when a confidant is needed.

If there is a threat of suicide, teachers should activate

intervention and participate in recovery. Suicide must no longer be an option. Youth must be helped to learn to take responsibility for their lives. They need to gain personal confidence and look to the future with an optimistic attitude.

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